PART III

SOUTH DAKOTA STATE PLAN ATTACHMENT 4.19D
REIMBURSEMENT FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED UNDER 16 BEDS

1. The purpose of this plan is to define the methodology for the establishment of reimbursement rates for ICF/MR facilities under 16 beds participating in the State's Medicaid program. Provisions of and payments under this reimbursement plan shall begin July 1, 2002.

2. A uniform report furnished by the Department of Human Services, shall be completed and submitted to the Department within 138 days following June 30. The following criteria apply to all reports:

   a. Reports shall be completed following generally accepted accounting procedures and the accrual method of accounting.

   b. Reporting period shall cover the twelve month period, July 1 through June 30.

3. All providers shall be required to keep all financial and statistical records for a minimum of six years following the submission of cost reports and these records must be made available to the Department of Human Services and/or Medicaid Fraud Unit (MFCU) and/or Department of Health and Human Services (HHS) upon request. In no instance shall the records required by this paragraph be knowingly destroyed when an audit exception is pending.

4. All cost reports submitted will be maintained in Department files for a minimum of six years or until any audit exceptions are cleared, whichever is longer.

5. The provider shall identify all related organizations to whom reported operating costs were paid. Identification of the amount of these costs, the services, facilities, supplies furnished by or interest paid to a related organization shall be attached to the annual cost report. Costs shall not exceed the lesser of actual cost to the related organization or the open market cost.

6. Rent paid to a related organization shall be disallowed and actual cost of ownership shall be reported. For purposes of this plan, cost of ownership is defined as mortgage interest, plus depreciation on building(s), plus depreciation on equipment, plus repairs to building(s), plus repairs to equipment, plus insurance on building(s), plus insurance on equipment, plus property taxes.

7. Participation in the program as a provider of ICF/MR services shall be limited to those facilities that accept as payment in full the reimbursement established under this plan for services covered by the plan.

8. Allowable costs are based upon criteria as defined in HCFA-15, Provider Reimbursement Manual, except as otherwise described below.

Routine Services. Routine Services shall be defined as those services and items which are necessary in meeting the care of the residents. The following items and services will be considered to be routine for purposes of Medicaid costs reported.

a. All general nursing services, including administration of oxygen and medications; handfeeding; care of the incontinent; tray service; normal personal hygiene which includes bathing, skin care, hair care, nail care, shaving, and oral hygiene; enema; etc.;

b. Items which are furnished routinely and relatively uniformly to all residents, such as resident gowns, water pitchers, bedpans, etc.;

c. Items stocked at nursing stations or on the floor in gross supply and distributed or utilized individually or in small quantities, such as alcohol, applicators, cotton balls, Band-Aids, linen savers, colostomy supplies, catheters, catheter supplies (eg, bag), irrigation equipment, needles, syringes, I.V., equipment, T.E.D. hose, hydrogen peroxide, O-T-C enemas tests (Clinitest, Testape, Ketostix), tongue depressors, facial tissue, personal hygiene items (which includes soap, lotion, powder, shampoo, deodorant, toothbrushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, etc.);

d. Items which are utilized by individual residents but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, alternating pressure pad and pump, other durable medical equipment, etc.;

Social Services and Activities including supplies for these services;

e. At least 3 meals/day planned from the Basic food groups in quantity and variety to provide the medically prescribed diets. This includes special oral, enteral, or parenteral dietary supplements used for meal or nourishment supplementation, even if written as prescription item by a physician - as these supplements have been classified by the FDA as a food rather than a drug;

f. Laundry Services;

g. Active Treatment Services for developmentally disabled residents;

h. Therapy services;

i. Transportation services necessary to meet the medical and activity needs of the residents exclusive of ambulance services and specialized wheelchair transportation services;

j. Oxygen, regulators, tubing, masks, tents, and other equipment necessary for the administration of oxygen; and

k. Oxygen concentrators.

Non-Routine Services. These services are considered ancillary for Medicaid payment. The costs of these services should be accounted per instructions for completing the cost report. Such billings are to be made by the supplier and not by the nursing facility. These services include, but are not limited to:

a. Prescription Drugs;

b. Physician services for direct resident care;

c. Laboratory and Radiology;

d. Mental Health Services;

e. Therapy services when provided by someone other than a facility employee; and

f. Prosthetic devices and supplies for prosthetic devices provided for an individual resident.

9. Building depreciation shall be limited to 3% on masonry and 4% on frame buildings and shall be calculated on the straight-line method. Generally accepted accounting procedures will be used in determining the life of any addition(s) to primary structures.

10. Depreciation on fixed equipment shall be calculated on the straight-line method, following the American Hospital Association (AHA) Guidelines for any item(s) purchased after January 1, 1987.

11. Depreciation on major movable equipment, furniture, automobiles, and specialized equipment shall be calculated on the straight-line method, following the American Hospital Association (AHA) Guidelines for any item purchased after January 1, 1987. Deviations from the AHA Guidelines may be granted in those instances in which facilities can provide the Department with documented historical proof of useful life.

12. Allowances may be made for known future costs due to new or revised federal or state laws, regulations and/or standards having an impact on costs incurred by long term care facilities. An explanation of costs of this nature must be attached to the Cost Report if they are to be given consideration.

13. Statewide averages and allowable per diem rates shall be set annually prior to July 1.

14. A per diem rate shall be established and paid for each Medicaid eligible resident in a facility.

15. In computing annual per diem rates, costs subject to the inflation shall be inflated on the basis of the United States Consumer Price Index as reflected by the forecasts received from DRI/McGraw Hill, Inc. each year.

16. Annual rates shall be established prior to July 1 of each year. Department rules, or policies, shall be final. Interim rate adjustments may be made for the following reasons only:

a. Adjustments for erroneous cost or statistical reporting discovered during the course of an audit;

b. New or revised federal or state laws, regulations and/or standards having an impact on costs effective during the twelve-month period for which rates have been established;

c. Special circumstances arise that warrant an interim rate adjustment. Requests for interim rate adjustments due to special circumstances shall be submitted in writing to, and shall be approved by, the Secretary of the Department of Human Services. Cost increases to meet existing laws or regulations or to provide appropriate care for residents admitted to a facility shall not justify an interim rate adjustment.

17. Provisional per diem rates shall be established for new providers, using 110% of the average rate of current providers. Providers experiencing new operational ownership shall receive the per diem rate of the previous owner.

18. For reimbursement purposes outlined under this plan, any lease agreement entered into by the operator and the landlord shall be binding on the operator or his successor(s) for the life of the lease, even though the landlord may sell the facility to a new owner. For reimbursement purposes outlined under this plan, the only exceptions for permitting the breaking of a lease prior to its natural termination date shall be:

    a. the new owner becomes the operator; or,

    b. the owner secures written permission from the Secretary of the Department of Human Services to break the lease.

19. No reimbursement shall be allowed for additional costs related to sub-leases.

20. The reimbursement rate for out-of-state facilities providing ICF/MR services to residents of the State of South Dakota shall be the lesser of the Medicaid rate established by the state in which the facilities are located or the average Medicaid rate for the bed size and type of service level applicable to in-state facilities.

21. The occupancy factor used in calculating per diem rates shall be the number of resident days recognized by the department upon completion of the desk audit.

22. The facility's records shall be audited annually by an independent accountant. The audit shall meet all the requirements of the Office Management and Budget Circular A-133 and be forwarded to the agency setting its rates.

23. All audit exceptions shall be accounted for on the HCFA 64 in accordance with the State Medicaid Manual, Part 1, Section 2500.

24. An "add on" payment will be allowed when the State Office of Adult Services and Aging makes a determination that a resident of an intermediate care facility for the developmentally disabled requires total parenteral or enteral nutritionally therapy and the resident is eligible for Medicaid but not eligible for Medicare. The amount of the "add on" will be $25.00 per day and will not be subject to any maximum or ceiling.

25. An add-on payment for the cost of ventilator equipment and supplies is allowed when a resident of an intermediate care facility for the developmentally disabled is ventilator dependent. A physician's order must document ventilator dependency.

26. When establishing annual per diem rates, the total "add on" payments made to a facility during the time period covered by the cost report will be used as a credit adjustment to dietary costs shown on the cost report. In addition, an adjustment will be made to dietary costs for known private pay

residents receiving total parenteral or enteral nutritional therapy. The amount of the private pay adjustment will be equal to the "add on" payment established in section 26 and 27 multiplied by the number of days that private pay residents received total parenteral or enteral nutritional therapy or ventilator services.

27. The Department may withhold payment to facilities for non-compliance with any provision of this plan.